ASSEMBLY BILL No. 1226

Introduced by Assembly Member Runner

February 26, 1999

An act to amend Section 1367.215 of the Health and Safety Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

AB 1226, as introduced, Runner. Health care.

Existing law requires every health care service plan contract that covers prescription drug benefits to provide coverage for prescribed pain management medications for terminally ill patients when medically necessary, and requires the plan to approve or deny the request by the provider for authorization of coverage for an enrollee who has been determined to be terminally ill in a timely fashion, appropriate for the nature of the enrollee's condition, not to exceed 72 hours of the plan's receipt of the information requested by the plan to make the decision.

This bill would apply these provisions to patients who have been diagnosed as having intractable pain, as defined.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 1367.215 of the Health and Safety Code is amended to read:

1367.215. (a) Every health care service plan contract that covers prescription drug benefits shall provide coverage for appropriately prescribed pain management medications for terminally ill patients*, or for patients who have been diagnosed as having intractable pain, as defined in Section 2241.5 of the Business and Professions Code,* when medically necessary. The plan shall approve or deny the request by the provider for authorization of coverage for an enrollee who has been determined to be terminally ill*, or who has intractable pain,* in a timely fashion, appropriate for the nature of the enrollee's condition, not to exceed 72 hours of the plan's receipt of the information requested by the plan to make the decision. If the request is denied or if additional information is required, the plan shall contact the provider within one working day of the determination, with an explanation of the reason for the denial or the need for additional information. The requested treatment shall be deemed authorized as of the expiration of the applicable timeframe. The provider shall contact the plan within one business day of proceeding with the deemed authorized treatment, to do all of the following:

(1) Confirm that the timeframe has expired.

(2) Provide enrollee identification.

(3) Notify the plan of the provider or providers performing the treatment.

(4) Notify the plan of the facility or location where the treatment was rendered.

(b) This section does not apply to coverage for any drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration. Coverage for different-use drugs is subject to Section 1367.21.

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